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ABSTRACT

This paper explores the thesis that a discrepancy exists in the treatment of physical disease over mental illness when care is provided by Health Maintenance Organizations (HMOs). Inconsistencies exist in the form of narrowed and abbreviated treatment models coupled with outmoded views towards mental illness. Strategies currently used by HMOs to limit the treatment and care of mental illnesses such as substance abuse can also be used to restrict access to marriage and family therapy. HMOs also do not take into account individual differences, and have a complete disregard for environmental, demographic, and multicultural factors. After chronicling the history of HMOs in the United States, the paper explores the effects of HMO decisions on consumers. It reports the results of the questionnaire distributed to consumers, providers, and executives to determine if the consumer is being denied qualitative mental health care. It concludes with an exploration of more humanistic and acceptable alternatives to mental health care. With this paper the author hopes to: (1) educate newly licensed mental health practitioners to issues regarding HMOs in order that they can protect their interests while maintaining integrity in their treatment of mental health patients, and (2) promote awareness of any ethical concerns that might result as HMOs dictate treatment for mentally ill patients. (Contain 47 references and three appendixes.) (Author/JDM)

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An Exploration of the Delivery of Mental Health Care by HMOs

An Independent Research Project

Presented by

George V. Daukantas

To

John Twomey, Ed.D
Faculty Advisor

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Psychological Studies

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An exploration of the delivery of mental health care by HMO's

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It is the thesis of this IRP that discrepancies exist in the treatment of physical disease over mental illnesses at the hands of Health Maintenance Organizations (HMO's). Such inconsistencies exist in the form of narrowed and abbreviated treatment models coupled with outmoded views toward mental illness, lack of taking in to account individual differences, and a complete disregard for environmental, demographic and multicultural factors. After chronicling the history of HMO's in the United States and the traditional protection of CEO's from liability, this IRP explores the effects of HMO decisions on consumers. The results of questionnaires distributed to consumers, providers and executives are analyzed. Lastly, this IRP explores more humanistic and acceptable alternatives to mental health care.

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INTRODUCTION

The Problem

When fee for service schedules were replaced by corporate - sponsored reforms, the administering of care and relegating of dollars to providers opened a Pandora's Box. The aborted attempt at health care reform caused a tightening of the health care dollar. Emphasis was placed on profit. Insurance companies bought policies in bulk and sold them to HMO's, and employers bought insurance plans from HMO's at low cost. All profits were channeled to distant parent companies , dialogued by Boyle and Callahan (1995).

Recent consumer concerns have caused medical litigation alerts. Health care professionals interested in providing ethical and responsible care voiced their concerns. In mental health, the prime reason for concern stems from issues related to available forms of treatment. The accountability to third parties, the limits imposed on treatments, and controversial issues such as involuntary commitment, sterilization, and the lack of providing therapeutic care to HIV/AIDS clients or eating disorders began a campaign to examine whether any ethical issues were being violated. The existence of therapies available to the more affluent, not now available to people in the general public with emotional health disorders have caused concern. Such restrictive attitudes on the part of HMO's have caused mental health care providers to sometimes question these administrative policies. The restrictive attitudes and questionable policy motives are the areas which this IRP will specifically examine.

The problem is further enhanced by assertions that mental health is a minority interest. Pharmaceutical companies promote the biological reductionism of mental illness. The legislative and regulatory fronts have insurance and managed care companies devoting millions of dollars to lobbying. According to Bittner , Bialtek , Nathiel , Ringwald ,and Tupper (1999), some are arguing that outpatient psychotherapy, like cosmetic surgery, should be thought of as an elective medical procedure and not be paid for by health insurance at all. Therapists are asserting that people utilizing mental health care are stigmatized. Who can argue that pneumonia, diabetes, brain tumor, have fairly predictable courses as opposed to school failure, bipolar disorder, or spousal abuses? Is there a way to show better evidence that psychotherapy used for family systems problems or mental illness has as good or predictable an outcome as a medical problem? This research paper will hope to identify such issues and invite an audience of future and aspiring professional counselors to engage in a discussion which has both relevance and freshness of concern .

Historical Context

First created in the 1920's, HMO's, or prepaid group practices, have become very popular over the past decade because of their success at making high quality care more available and less costly. More than 2.2 million Massachusetts residents receive their health care through HMO's. Unlike ordinary insurance, in which patients pay a fee each time they receive medical services, HMO's provide health care coverage for a fixed monthly premium that is, on average, much lower than the costs of old style health insurance. Moreover, while ordinary insurance commonly covers only 80% of many

medical expenses, HMO's usually have minimal or no co-payments and do not require members to pay deductibles. Not only do these practices save consumers money, they remove financial barriers that can prevent people from seeking treatment early, before health problems become severe. HMO's take an active part in helping their members by employing or contracting with select networks of doctors or therapists, hospitals, and other types of health care providers. HMO members use providers within their plan's network. This system has enabled HMO's to control health care costs as well as monitor providers for quality. Because HMO's direct a high volume of business to providers within a network, providers are able to offer HMO's lower prices for their services.

Overview

The purpose of this Independent Research Project is to examine the conditions under which HMO's grant care to mental illness. It will also focus on addressing the question of what "best interests" the HMOs consider in granting patients care, and how these interests are prioritized. Chapter One will offer an involved chronology of the health care system in the United States and the inception of HMOs. Chapter Two will outline how the current managed behavioral care views mental illness compared to physical illness – and the nature of both CEO protection from liability ,and the concerns of clients and therapists. Chapter Three will profile individual clients with (eating disorders or HIV/AIDS being deprived of protease inhibitors , et al.) who have been victims of the system, as well as professionals working under the HMO restraints. It shouldn't be this way, and there should be alternatives, which will be explored in Chapter Four. Options will be presented such as health marts, kidmarts, and services not subject to federal/tax reviews, and sponsored by consumers themselves and their

advocates in having a say in what they want and need. Lastly, an exploration will be made as to who makes the decisions regarding granting patients care and how such decisions are made.

Above all, this IRP is designed to promote awareness to individuals and promote the cause of therapeutic unity. For example, the providing of legislative changes that allow professional counselors to be reimbursed by the largest HMO's such as Medicare could open the door for elderly citizens to be provided outpatient visitation and treatment options while providing reimbursement for professional counselors.

Rationale and Population

The rationale for attempting this project is to amplify a topic of major and breaking relevance. Its freshness of concern for clinicians, students and clients hopes to justify a topic that examines discrepancies in the delivery of care for physical disease and mental disease. Both sides of the health care spectrum will focus on how HMO'S consider mental health care delivery. Interviewing the top, middle, and bottom tiers of personnel in the delivery of services provided a view of how mental health clients qualify for their mental health treatments.

Discrepancies in the provision of care provided to mental health care clients over those with physical diseases are analyzed using raw data drawn from questionnaires. The focus will attempt to show a uniqueness about such services provided by such HMO's as *The Harvard Pilgrim Health Plan, The Tufts Health Plan, HMO Blue, Caritas Christi* and others.

This IRP is intended to address such discrepancies and may be significant to those beginning their counseling careers and to those who may wish to reassess their priorities in treating human beings.

Methodology

The resources to be tapped from in the formation of this IRP are two-fold. The first form consists of primary sources which include face to face and telephone interviews which were written and elicited by the use of surveys and/or questionnaires presented . Primary sources also include correspondence between the author and professionals, experts or policy makers in the field who have opinions on these issues. Finally are write ups of television and/or radio interviews or discussions on the topic of HMO's and mental health care. As a result of all these interviews, questionnaires and correspondences, the data have been dissected and scrutinized as to determine if the consumer is being denied qualitative mental health care .

The second set of resources are secondary sources, such as on-line information; magazine, journal and newspaper articles; books on this topic; and printed information from HMO's themselves, as well as from any other related sources such as the American Counseling Association (ACA).

Means of Analysis

Demographics: A total of five people have responded to the request by the researcher via televised interview and questionnaire. The number of participants was limited to five because of time restraints.

Questionnaire Prompts: (tables are offered in Appendices to show percentages)

To Consumers

1. Do you see yourself as treated any differently from a physical disease?

2. Do you feel any service has been denied?

3. Do you subscribe to any HMO for your mental health problems?

4. Do feel a "Patient heal thyself" philosophy has been created?

5. Do you feel out of the "mainstream" of society ?

6 . Is there anything more you would like to say about your experience today?

For Therapists and Clinicians

1. Do the clients or consumers to whom you provide a service feel neglected?

2. Do you feel as if you are providing " Step Child " treatment?

3. Do you subscribe to an HMO for your mental health problems?

4. Do you feel there are limits place upon your treatment options?

5. Do you feel a "Patient heal thyself philosophy" has been created?

6. Is there anything more you would like to say about your experience today?

For Executives

1. Is there anything unique about the service you provide?

2. Do you feel responsible if the therapist is ever responsible for providing negligent care?

3. Will the therapist to whom you provide reimbursement have a controlling interest in deciding what type of care or therapy is provided?

4. Do you prefer a "Closed" or "Open " style of management?

5. Do you feel yourself to be in the health care business?

6. Will the therapist to whom you provide reimbursement have a controlling interest in treatment decisions?

7. Is there anything more you would like to say about today's experience.

OUTCOMES

It is the purpose of this research paper to demonstrate a lack of clarity on the part of the current behavioral health care organizations and the service delivery for mentally ill groups as it affects professional counselors. The paper is indicating demonstrable proof that the introduction of managed behavioral care has had an impact on clinical mental health practice. The research paper was an attempt to present an impartial and verifiable frame of reference to "New Clinicians."

J

(jmyer@juno.com 1999) states the clinical directors offering in an outpatient care are experiencing either total cooperation from a managed care company or very little cooperation. The directors dealing with uncooperative MCO's indicate treatment that borders on malfeasance. The research paper also indicates that that the uncooperative managed care companies do not understand disease or the clinical process. In these cases, the decisions are usually left in the hands of the bean counters . Therapeutic options that are available are usually minimal and are a return to the team approaches. Psychiatrists administer medications, psychologists will return to psychometry, and therapists will provide stabilizing therapy at a lower price.
The recent TV expose of the Charter Hospital Situation in adolescent inpatient care indicates what happens when sub/master's clinicians do the bulk of limited tharapy (jmyer@juno.com).

The research paper also highlights necessary clinical preparation for managed care organizations. At this time very few organizations are adequate preparation for managed care organizations. First , Existential therapies do not seem to lend credence to hard and cold , dollars and cents issues concerning managed care organizations. Second, Any therapy that is not resolved within three to five visits is considered ineffective and terminated. These have nothing to do with most mental illnesses. Inpatient units are designed for stabilization, partial hospitalization has limited effectiveness, outpatient therapy is limited to shorter contacts and more paper work having little to do with effective therapeutic change.

Accordingly, most counselors will need to have brief therapy cures for clients with documentable results. These factors along with my research paper indicate a present current behavioral managed care system that rates itself more on monetary gain for the businessman and less on treatment outcomes for patients and consumers. These factors are a wake-up call for all aspiring and reliably competent counselors and therapists.

The findings of this investigation concludes with Myers and Beck all of the that professional counselors should be involved in encountering the maximum professional respect from their consumers and colleagues and insurers whether in individual or group private practice (esbl@juno.com). IPA and GPA tables indicate that screening, exclusion, referrals to outside organizations and gatekeeping are all tools available for distant parent organizations and their Chief Executive Officers in a " *closed* "or "*open* " style of management. Restrictive therapies are often restrictive for the client . Restrictions placed on aspiring counselors and therapists are being observed

and reported. Managed behavioral care organizations are not willing to allow either physicians or therapists a full reign on decision making for enrolled clients because of apparent expense related issues and confidence in the profession.This evidence bears out the support for a tendency for profit margin over effective treatment .The authors that have published a template for brief therapies are included in the research paper and the rationale for their acceptance is in the text.

The writer postulates that the New Clinicians of the 21st Century need to be versed in the protocol and the nuances , alternatives and risks in dealing with managed behavioral care organizations. These findings have pragmatic value for educators and clinicians in planning their programs and curricula.

LITERATURE REVIEW
An Exploration of the Delivery of
Mental Health Care by HMOs

A comparison between how today's HMO's are approaching disease management is asking if physical illness is approached differently from mental illness and the categories that seem to matter most in answering the question, " Is quality of care in a for profit versus fee for service environment different in a market oriented health care system?" This IRP will put together ten to fifteen major, relevant, and current sources highlighting the strengths, weaknesses and the alternatives as well as the key advocacy concerns of interested parties. The summary of each point of view will be discussed and will describe the staple features of management styles and concerns by CEO's and executives, patients, families, and third party liabilities for therapists as well as the reasoning behind the current trend.

Boyle and Callahan (1995) dialogue on managed care citing that the ethical issues that offer praise and blame for managed mental health care are on the rise. As in general health, managed care in mental health is neither good nor evil as its advocates or detractors would have us believe. Critics contend that the reduction of services jeopardize therapist/patient relationships. Supporters counter with evidence that managed care can broaden access to needed services. They write that the ethical issues for mental health care need some resolving based on certain criticisms.

Further, the authors Boyle and Callahan (1995) have evidence that indicates that health care and mental health substance abuse (MH/SA) treatment costs are burdening U.S. businesses, possibly making it harder for them to compete internationally. Supporters of managed mental health care sometimes suggest that if

persons now excluded from the system of fee for service form a compelling argument for managed care that expands access to care and uses dwindling health care resources and cuts down on the use of unneeded services. The opponents of managed care believe that the reductions in the intensity of services engender a range of generic complaints, but especially charge that managed care harms the quality of, and access to, care and the provider /patient relationship. They cite cases in which managed care techniques applied to mental health have had disastrous results. These techniques include rejecting elective outpatient visits and inpatient days, increased co payments for outpatient visits, establishing gatekeepers, using non -psychiatrists for mental health care other than medication management, and requiring specialized utilization review.

Boyle and Callahan (1995) continue by saying that, often overlooked, the new attempts to manage mental health care sometimes simply continue practices found in fee for service medicine. There is renewed ethical concern about the means managed care uses to limit intensity of services. The authors write that the fears of mental health care adversaries are not unfounded. Mental health services have long been the neglected step child of health services. The increased management of mental health services often rides on the long standing discriminatory policies against covering mental illnesses.

Historically, mental health services have not received the same public or corporate support as physical health services. Private and public funding often limits mental health coverage for illnesses of the same scope and intensity. Traditional insurance plans as well as HMO's customarily restrict mental health benefits more

stringently than they do medical care benefits, by setting caps on numbers of hospital days or outpatient visits, or by imposing annual dollar or lifetime limit as reported by Boyle and Callahan. These authors write that a long standing complication for mental health advocates is a relative lack of proof of the effectiveness of mental health treatments. Remedies for the severe and persistently ill are perceived to be almost futile, and relief for the worried well is thought to be discretionary care is typically thought to be lengthy and expensive. While these contentions are somewhat overstated, in the absence of convincing research it is often difficult to distinguish established interventions from the latest models of care. The lack of agreement regarding effectiveness gives rise to conflict even among mental health advocates. They argue, for example, about the effectiveness of psychotherapy as compared with more medically -oriented services, the appropriateness of involuntary commitment ,and the effectiveness of family- based or group interventions. The lack of good data on treatment expenditures and costs increase the disagreements over effectiveness as reported by Boyle and Callahan.

The same authors write of the realization that there is no "artesian well" of health care resources. In fact there is justifiable doubt that the health care system can ever offer everyone everything they need or want, given the legitimate competing demands of other financial resources from such areas of public safety; education, and defense, and the public's increasing unwillingness to pay more in taxes for these public services. The specific criticisms of managed mental health care could adversely affect the quality of care. The contention is that managed care is inevitable, but that this need is no more troubling than fee for service mental health systems.

The primary focus here was the individual patient and therapist. This focus completely neglected the social fabric in which these individuals were imbedded; issues of greater access to care than with the fee for service system are not irrefutable. This judgement comes with the stipulation that managed mental health care organizations be explicit and expert about the benefit plan design, quality and access to care in addition to therapist/patient relationship, and the appeals process.

According to Kagle and Doner and Kopel (1996) who dialogue the nature of mental illness, decision making problems for persons with mental illness and the necessary service to treat persons with mental illness create special problems ethically with public policy challenges. Limiting or denying services is supported by managed care believers. A budget of fiscal and clinical accountability is the greater potential virtue and moral defense of managed care. Managed care systems raise the awareness that the limits on services affect not only the poor and those with catastrophic needs, but the middle and upper-class purchasers who, previously, could get whatever they wanted as well. Whatever the case, the authors stipulate that the key question is, " Is the case for denying or limiting care ever justifiable?"

The criticisms of Boyle and Callahan (1995) on managed mental health care include a mandate that could assert that there is a means of cutting costs in managed mental health care and that will necessarily have an adverse affect. This argument is supported by saying managed mental health care supports less costly providers and treatments and that a lower intensity of quality of service and quality is harmed because of non psychiatric mental health care gatekeepers who are insufficiently trained about the effects of other decisions in treatment quality.

Boyle and Callahan (1995) succinctly add that managed mental health care could adversely affect informed patient choice. The growing concern is that managed mental health care could insufficiently promote informed decision making at both enrollment and point of service plans. Point of enrollment plans refer to the services not provided by the insurance plan. Problems with informed consent affect persons with psychological disorders. Until 1991 managed mental health care providers have kept their decision making criteria and protocol "secret" when referring clients for network mental health services. In any event there is no parity between mental health plans, managed or unmanaged. Employers, unions, and corporate health plans generally establish these benefits with or without good consultation. Referral preference is given to biologically based mental illnesses. Today, this is more evident in corporate plans, that provide benefit packages designed on a medical model as according to Boyle and Callahan (1995).

It has been said that federal consumer laws may only complicate the issue ; there are attempts to focus Congress on managed care consumer protection legislation. The " Patient's Bill of Rights Act" (H.R. 358/S.6) is a comprehensive bill that contains strong pro-consumer language. Also, bills such as the "Medical Information and Privacy Act" (S.573/H.R. 1079) will protect "medical confidentiality" and "privileged communication" through confidentiality legislation. At this writing, I am pleased to report that a Bipartisan Consensus Managed Care Improvement Act of 1999 was passed on October 8th,1999. H.R. 2723 won a surprising victory for consumer and provider advocates . The winning legislation will be conferenced on the Senate Floor in the coming weeks. The American Counseling Association feels those that stood for a

hard won and tough victory did the right thing according to Loretta Bradley, President of the American Counseling Association. I am proud to be able to report that I voted for "*Medical Confidentiality* "and " *Patient Rights*" through my member ship vote with the American Counseling Association.

The first six articles are a criticism of HMO service delivery in the form of complaints by consumers and providers. The next three articles are a defense of the strengths of the HMO's and the remaining articles will present state of the art alternatives to standard forms of treatment. First, making known the perceived weaknesses in service delivery by HMO's, advocates for the mentally handicapped and the profession of therapists providers seem to be saying the treatment decisions in client/ therapist relationships are being taken from them. Also, the advocates say there is a cheapness and downsizing effect for treating mental illnesses. Also, they say that therapists are being "socialized" to providing " appropriate" treatment as reported by Finkelstein (1996). A Manhattan based therapist states that she has to reapply to the MCO's for permission to continue treatment as often as every five sessions. Her request are often ignored or denied. To the therapist, the attitudes toward mental health under managed care is "step child " treatment according to Finkelstein (1996).

Also, a head of the national coalition of mental health professionals and consumers says that she was unable to provide the best therapy when she briefly worked with managed care. She felt that her training would have asked her to slow down and see if there was something that the patient was avoiding according to Finkelstein (1996). To the advocates of rights, the sweeping, destructive effect many clinicians feel managed mental health care has on it's clients is evidenced by 62

million Americans now under the Magellan Group headed by Richard Rainwater, of Columbia/HAC, probably the country's largest Managed Behavioral Care Organization. It traded 1.5 billion dollars last year. The steady stream of mergers and acquisitions has had an effect on patient benefit packages as written by Finkelstein (1996).

Goldberg (1998), advocate and writer, critiques MCO and HMO executives referring to the current mental health care system as a marketplace. But, it is nothing of the sort. Patients are not consumers because they do not directly choose their own health insurance plans. Large corporations buy health insurance in bulk for their employees and let the HMO's restrict access that would reduce costs. In other words, they gave HMO's what amounted to monopolistic control over medical services because managed mental health care could set the prices they paid for care and control what services patients used.

Further, Goldberg (1998) writes that HMO's oppose congressional proposals to let people buy their own health care from an array of competing systems. Health Marts and Kid Marts could be exempt from state and federal health benefit regulations. Reports by Lerner (1999) attest that lobbyists are pushing ahead to legislate the removal of confidentiality in patient medical records and verbatim transcripts which are open for all to see. Regardless of who is right, Finkelstein (1997) attests that the new managed behavioral care companies are running the show their way and that way is also their cheapest way.

There exist four strategies available to managers who "apportion" health care dollars. The first is to develop financial incentives for providers, then they negotiate

contracts with purchasers and coordinate activities of service providers as reported by Jensen and Bartlett (1991).

HMO's operate in a closed environment. Although there are other options available to their CEO's such as a "laissez faire" policy that involves personnel managers and line managers a say in policy decisions, these are generally not accepted. The best suited style for CEO's is a "closed" style in increasing profit margin. Contractual agreements consider " brief" therapies as models that address disorders to produce change after twelve or so visits and a follow up after two to three months as reported by Jensen and Bartlett (1999).

Pham (1998) indicated in a report from the National Committee on Quality Assurance (NCQA), that the Massachusetts Medical Society suggests that while doctors were generally satisfied with health plans, they are annoyed with the administrative hassles of dealing with HMO's Specifically, the industry's use of financial incentives to mould physician behavior is a matter of concern. As of this writing, Physicians are forming "Doctor's Unions" to protect the perceived damage created by merging HMO's.

The authors of the " Brief" therapy model (A.S. Gutman and S.H. Budman,1981) , both psychiatrists the model for therapy presented outlined the model after which the MCO's planned their treatment options. The HMO's authorized treatments based on models that were a template in "Self Help" to be applied to all types of mental disease. However, watchdog advocates using the national quality assurance guidelines set by the NCQA using "compass quality " flunked the model on at least nine categories. The literature concerning these current trends are leading to liability

concerns for therapists under managed mental health care organizations as reported by Finkelstein (1996).

Roy (1998) defends HMO's and MCO's and defines such articles that explain how patients were herded into managed care after President Clinton's 1994 attempt at Health Reforms failed. Consumers rarely knew the details of their benefit plans and changes in reforms. Health reforms had failed for a Democratic president and limitations were placed on mental health coverage, education of patients, explanation of the restrictive treatments, limits on unnecessary "treatments", building trust, empathizing and building a relationship from the first encounter helped cushion the exposure for patients entering into managed mental health care organizations as reported by (Lowes , 1998). Managed care will pay for every bit of health care you need, but it will not pay for every bit of health care you want. There's a difference .

The current literature shows works by Lowes (1998).They review the chain of command established in managed care organizations since the old forms of insurance were in place. They include and exhibit a " closed " management style in which the CEO does not include line managers and personnel officers in any of their policy decisions. Screenings, referrals, gatekeepers, outside organizations, are all designed with the intent of limiting care, downsizing illnesses and limiting care as written by Lowes (1998). Jensen and Kane (1995) write that line mangers and personnel directors or other office personnel have virtually no say in policy and decision making established by a CEO.

Issues of privileged communication and confidentiality and accountability in record keeping and note taking and documentation require that psychotherapists enter

brief, problem oriented approaches in documentation and professional standards that include client, family, attorneys, courts and other interventionists as reported by Bertsche and Horejsi (1980).

Fiscal responsibility, the rational allocation of scarce treatment resources and the " medical necessity" of treatments are now emphasized. The payer currently has a fiduciary responsibility to ensure that contracted services are provided. The monitoring and accountability of psychotherapist practitioners now require that they provide documentation that treatments are not expensive or unneeded according to Bertsche and Horejsi (1998) and Kane (1974).

Twenty - three years after the Tarasoff v. The Regents of the University of California decision, the liabilities and the limits made on "confidentiality" have resulted in placing the therapist/practitioner on their heels with the accountability to third parties and non- patient entities as reported by Kagle and Doner and Kopels (1994).

The Ramona v. Ramona decision of 1996 and the implications in court cases included references to liabilities to third parties and non patient to sue a psychotherapist and subsequently cracked a hole in the wall of therapist 's protection from liability. This decision represented a turn about in the longstanding standard in legal thought as written by Applebaum and Zoltek and Rose (1996).

Remley and Remley and Herlihy (1997) have written that the Jaffe v. Redmond decision has established a "legal" precedent that guarantees " privileged communication " status to licensed psychotherapists over and above the simple ethical " confidentiality" principles. As a result, Callahan (1996) writes that therapists may need to back away from more directive approaches that would affect third parties.

Even comments made to encourage patients to examine their behaviors more carefully may need to be seen in a new light. When a third party has been named by the actions of a therapist, the courts will be sorely tempted to afford that person a remedy. The Ramona decision offers an opportunity for psychoanalysts to consider if the pendulum has swung too far the other way with regards to the directive interventions with patients. The discussion of alternative courses of action on how to proceed may be much safer from a liability perspective. Also, this approach could be a preface of greater accountability in the face of complex problems with respect to a patient accountability. Real (1990) offers such alternatives in developing five stances for guiding the therapeutic use of self eliciting, probing, contextualizing, matching, and amplifying. Perhaps narrative approaches to therapy , novelizing a patient's reality, using multiple realities to explain a search for meaning, and doing therapy *with* a client rather than *to* a client would balance the equation as reported by Cecchin (1987).

Bednar (1989) writes that in case law, the courts have increasingly ruled that therapists must take appropriate steps to protect certain third parties. However, the jurisdictions to which third parties and the therapists must protect is still a gamble and a series of guidelines concerning the assessment and management of risk, the documentation of information and activities, the formulation of written policies, and damage control are realized, especially for reducing therapist's exposure to suit. The duty to protect third parties was first imposed by Tarasoff, 1996. Bednar (1989)writes that the California Supreme Court case of Tarasoff was the first to extend obligations beyond the limits of a therapists relationship with a client.

In the area of documentation and record keeping, Callahan (1996) has written that the early models of client records used to monitor client progress, education and supervision were called process recording. In process recording social workers attempted to document virtually everything that happens in a client session in chronological order. Special attention was paid to changes in topic and affective style. Process recordings were popular through the 1970's and were almost always psychodynamic in style. Over the past 15 years, standards and expectations have changed dramatically. There has been has been a gradual transition from narrative styles of documentation to brief problem oriented approaches written in behaviorally specific, concrete terms.

Current experts in the field Bertsche and Horejsi (1980) and Kane (1974) write that the increasing emphasis on monitoring of services by insurance companies, licensing boards, and regulatory agencies has been an important influence. By the 1990's, the goals and functions of record keeping had changed dramatically. The audience for the clinical record is no longer the social worker, supervisor, and colleagues. The new "wider audience" includes third party payers, clients themselves, and their families, and the courts. Increasingly, the central function of record keeping is monitoring and accountability. Accountability means that the record confirms that the social worker/psychotherapist is providing service claimed and that the service is done in a professional, competent manner.

Confirmation is a primary concern to third party payers, managed care firms, and health maintenance organization (HMO's) particularly, in a managed care environment, address fiscal responsibility, the rational allocation of scarce treatment resources and the

"medical necessity" of treatments . In these instances, the payer has a fiduciary responsibility to ensure that contracted services are provided. Demonstration that the treatment was consistent with professional standards of the field is targeted at an audience that includes the client, his/her family and attorney, and the courts. The interventions used by a psychotherapist include the use of risks with certain categories of clients, such as suicide risks, recording earlier treatments, potentials for violence and awareness that managed care's close scrutiny of the behavior of record keeping of psychotherapist and other clinicians underscores their importance as reported by Bertsche and Horejsi (1980) and Kane (1974).

Chapter One: History of Health Maintenance Organizations (HMO's)

HMOs are third-party reimbursable entities governed by a CEO who answers to investors and administrative magnates that monitor and regulate the delivery of health care based on a for profit basis. Its sole purpose is to generate revenues to perpetuate the existence of these newly formed managed care organizations, or MCO's. HMOs were instituted over the old reimbursement and fee for service insurance system when concerns arose that money was being spent and wasted for too many procedures, paperwork, and technology. Out of every health care dollar, it seemed that more portions of the dollar were being spent on administrative and salaried positions than on providing the care that the consumers wanted and deserved. Under the old system, consumers became pitted against providers when inordinate amounts of paperwork needed to be submitted before being provided any care, either on an emergency basis or on an outpatient basis. The response by the health care industry was to tighten the noose, muzzle the opposition and advance a profit-oriented, cost efficient way of providing care, such as HMOs.

The current health care system got to this state because costs were soaring , the professionals were not policing themselves , and the insurance companies blindly praised and paid for the moon. The mental health sector was not as guilty as the medical sector , because it never had high tech things to do, and reimbursement was for the most part tightly capped to begin with. In the late 1980's , the last straw occurred for mental health care. Hospitals engaged in flagrant abuse for admitting criteria's and lengths of stay . Abuses in inpatient hospitalization and widespread flagrant over treatment of the worried well in out patient treatment. The 1987

National Medical Expenditure Survey strongly suggests that even before managed behavioral care, few people sought mental health care.

Ten years ago, employers saw their profits eroding, mental health care was under funded. The Clinton administration tried to implement both cost control and universal coverage , yet his initiative was lost to lobbyists and political opponents. Managed care technology was firmly in place and mental health professionals joined panels thinking that it would be the only way to get paid, and we were all swept along by the seeming inevitability of mis -managed care. On the West Coast, the Medicaid population was extremely expensive and difficult to profit from. The redistribution of resources to those most in mental health need proved to be a bait and switch maneuver. Utilization reviews demanded extraordinary amount of personal information about clients which became part of electronic data bases.

According to (Hyatt,1996), the nation has experienced The American Revolution, The Industrial Revolution, The Computer Revolution, and now the Telecommunications Revolution. Yet, another radical alteration in American's ever changing lives has spawned the Managed Care Revolution. His article quotes him as saying " Wishful thinking will not impede the ongoing overhaul of the health delivery system many of us have enjoyed and thought would never end. Complete freedom of choosing a hospital, family doctor, and specialists is evaporating before our very eyes. Except for the affluent who are able to pay dearly for such an option. Managed care organizations, it cynically has been said, manage costs not care".

Bittner and Bialek and Nathieniel and Ringwald and Tupper (1999) have reported that in large part the struggle was over. We got "reformed "before we knew what hit

us. The question a few years ago was how to strike a balance between the art and science of psychotherapy as part of a life's journey and as a symptom-relief technology. These question now seem nonexistent. The bottom line seems major focus. Activist forces like the National Coalition of Mental Health Professionals and Consumers have been increasingly successful at informing the public of these problems. Legislation to regulate managed care is on the horizon, law suits based on a variety of premises (restraint of trade, libel of professional, practicing without a license, causing undue pain and suffering, are beginning to fill court dockets. The professional organizations are finally working on initiatives , including a patient advocacy organization to join in this process . The significant issue is that structural change in the form of business cooperatives contracting directly with competing behavioral health care systems rather than insurance companies. Health care policy is set in corporate board rooms and marketing departments: the explicit goal is higher profits , not a rational , humane mental health care system. In the meantime, families may be puzzled if not disappointed and enraged at what is happening when they call and seek therapy.

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As the horse and buggy doctor of old gave way to the overworked general practitioner who seldom had the time to make house calls, so the modern internist eventually had to call on the expertise of urologists, gynecologists, psychologists on which to diagnose and treat complex symptoms for which he or she was not specifically trained for. The internist became the dynamic center of the process as a service provider. The patient ultimately relied on his/her informed, objective judgements, warm concern, and personal relationships. The Physician, the Therapist, was a confidant, but that is changing swiftly. Pressure is applied to use particular hospitals, radiology centers and specialists who are on the HMO payroll.

Advances in medicine and recent public policy debates have produced a new lexicon of words and acronyms. The growth of HMO's and managed care is intended to help consumers by providing some basic definitions for commonly used HMO terms. For example, Capitation is a method of compensation for health care services under which doctors and other health care providers are paid a fixed monthly fee for a range of services for each HMO member under their care, rather than for each service or treatment they perform. Gatekeeper refers to a HMO primary care physician or therapist because of their responsibility for referring members to specialists or other services. Managed care is a method of delivering and paying for health care through a system of networks of providers. Managed care seeks to ensure the quality and contain

the cost of comprehensive medical care. Managed care plans include HMO's preferred provider organizations, point of service plans, and similar coordinated care networks. Networks refer to the doctors, clinics, health centers, medical group practices, hospitals, and other providers that an HMO or managed care plan employs or contracts with to care for its members.

Massachusetts HMO's are licensed and regulated by a variety of state and federal agencies. The Massachusetts Association of HMO's or MA/HMO's are 14 plans are in operation in Massachusetts, Aetna/US Healthcare; CIGNA Health Plan; Connecticare; Fallon Community Health Plan; Harvard Pilgrim Health Care; Harvard University Health Plan; Health New England; Healthsource CMHC; Healthsource New Hampshire; Kaiser Permanante; MIT Health Plan; Matthew Thornton Health Plan; Neighborhood Health Plan; Tufts Associated Health Plan and United Health Care of New England.

The insurance and managed care industries have been able to devote massive financial resources to promote their point of view. The forums are forming on three front: courtrooms, legislatures, and the media, where marketing will influence public opinion. Managed care companies are devoting hundreds of millions of dollars of their revenues , previously available for health care services , to marketing . The managed behavioral care message has been greedy. Professionals have harmed the public by their lack of accountability, that they create dependency in clients so as to ensure income., and they have failed to come up with standardized , measurable ways of treating mental illness.

Chapter Two : Managed behavioral care and CEO protection from liability

Chapter Two will outline how current managed behavioral care views mental illness compared to physical illness partly due to CEO protections from liability concerns of clients and therapists. While the new HMO's market themselves as health care providers, they and their members clearly believe that when responsibility is pointed to them, they state they are not in the health care business. The CEO and executives claim they are an insurance company and cannot be sued because they are protected by ERISA. ERISA is the acronym for Employee Retirement and Income Security Act of 1974 (ERISA). By citing ERISA, litigation in negligence case laws hold accountability squarely on the shoulders of therapist providers in breaches of confidentiality, HIV/AIDS issues, murder, suicide, eating disorders, child rape and molestation cases that include harm done not only to clients, but harm done to non patients. The early complaints of managed care were based on a moral analysis that assumed an idealized set of moral practices rooted in traditional patterns of medicine such as the Marcus Welby –type of doctor/patient relationship, unlimited choices for all patients and Cadillac care no matter what the cost as reported by Boyle and Callahan (1995).

The experts in the field, Boyle and Callahan (1995) write further that the moral challenges for managed mental health care in the current market place economics and service delivery are first, a challenge in the uneven split of power and responsibility between manager and therapist. If managed mental health care assumes some authority over treatment planning , it must bear its share of the burden of

responsibility. The other moral challenge is that the rise of managed care organizations shows clear the moral debate that is misfocused. Managed care's attempts to manage mental health care are on the upswing. Public reaction to this trend has been mixed, and the sentiments about managed care in mental health are all the more conflicted. Those who welcome managed care in the mental health are all the more conflicted . HMO's ,vendors of managed mental health care services, and employers believe that it will benefit patients, providers ,taxpayers and society. Skeptics believe that the trend toward managed care will limit patient choice of providers and treatments, reduce quality of and access to care , and disrupt the provider /patient relationship. Amid this tension, it is difficult to sift fact from fiction, and ethically defensible concerns from indefensible ones according to Boyle and Callahan (1995). But, if Congress passes legislation that does more to protect the public than any reform , then the companies and their CEO's can be sued when they cost patients their lives. They would be forced to put medical decisions and their medical care back where belongs, into the hands of the physician and the therapist as reported by Wachsman (1997). Rauber (1998) has reported that the HMO managed behavioral care model that has made millionaires out of hundreds of executives along the way , could be headed for perilous times . Klienke (1998) argues that managed care in it's current form is unsustainable and will cease to exist within a few years. The current model is incurring debt ,as is evidenced by latest trends in the stock market. Costs are jumping faster that the premiums in many markets. Observers warn that the best thing going for HMO's and managed care is a lack of credible alternatives.

Boyle and Callahan , (1999) describe Justice William Clark's opinion that a duty to warn should outweigh confidentiality . It is here, at this juncture that this writer asserts his first personal observation concerning a key difference in how mental illness differs from physical illness. Because that Tarasoff decision required a therapist to warn third parties of any potential danger to themselves the non-patients or their clients, there is a breach in what we consider the " Hippocratic Oath" or the "sacred secrets" learned while in the course of treatment of a disease. That breach between the observable healing power for a physical disease and the less tangible remission or cure of an emotional , behavioral, or cognitive disease is a key to understanding why such a suspicion is placed on those with mental disease.

Currently , stereotypes play a significant role in how others perceive the mentally ill or the homeless, and the homeless people today are perceived as the source of criminal and suspicious behavior and blame similar to what the African American experiences as a castigation and blame for criminal and suspicious acts and behaviors of others. This stereotyping acts to devalue and dis-empower multicultural people , the mentally ill, the homeless . The very process of psychotherapy is to empower and value , novelize and refocus , enrich and enlighten the experiences of people who are downtrodden and at a loss on how to end a viscous cycle of unwanted feelings or behaviors that are an antithesis to the direct aims of psychotherapy. Isn't the rationing and denying of care reinforcing the very systems that keep these stresses in place?

The professionals assert that write that tackling the managed care issues in mental health is generally acknowledged by researchers , and the cause of unequal treatment for mental illness stems from deep-seated convictions , service scandals, and widely publicized crimes committed by homeless persons, the mentally ill, or both , all fuel discrimination .In combining these factors, these beliefs have conspired to minimize treatment and funding for the mentally ill Those who welcome managed care in the mental health are all the more conflicted. HMO's, vendors of managed mental health care services, and employers believe that it will benefit patients, providers, tax payers and society. Skeptics believe that the trend toward managed care will limit patient's choice of providers and treatments, reduce quality of and access to care, and disrupt the provider/patient relationship. Amid this tension, it is difficult to sift fact from fiction and ethically defensible concerns from indefensible ones as reported by authors Boyle and Callahan (1995). The extent that managed mental health care is making - and continues to make - good faith attempts to curb abuses, rectify problems and address treatment effectiveness should prove superior on the whole to fee for service medicine as reported by Boyle and Callahan (1995).

Rauber (1998),has dialogued that the HMO managed behavioral care model that has made millionaires out of hundreds of executives along the way , could be headed for perilous times. Klienke (1998) argues that managed care in it's current form is unsustainable and will cease to exist within a few years. The current model is incurring debt, as is evidenced by latest trends in the stock market. Costs are jumping faster than premiums in many markets. Observers warn that the best thing going for HMO's and managed behavioral care is a lack of credible alternatives.

That may be subject to change. Gemignani(1998) , has reported that that a unanimous 9th Circuit Court of appeals reinstated a Washington law requiring insurers and HMO's to cover every type of state -licensed health care professional , including neuropaths, massage therapists, nutritionists, and acupuncturists. This ruling was a step in directing change to employee benefit plans . Justice Wallace Tashima wrote that " the appeals court decision of Physician Service Association et al. v. Christine O. Gregoire, "does not have anything to do with employee benefit plans in particular". It is merely one of many state laws that regulates one of many products that an employee benefit package might choose to buy.

Mark Ogoretz, president of the ERISA Industry Committee(ERIC), feels that this is a decision that is " disingenious" and ignores the letter and the spirit of the law. Gemignani(1998) reports that in it's decision, the 9th Circuit Court referred to the Supreme Court's landmark 1995 decision in the New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co. is widely seen as an erosion of ERISA. That decision, which upheld New York's right to collect hospital surcharges from employer-based health plans, found that the state law authorizing charges was not preempted because it did not directly affect the administration of employee benefit plans. Gemignani (1998) has reported that the resulting decision has offered insurers a quasi-medical service option. The outcome of such a decision gives practitioners a law which is validated by the courts , but also uses a single broad stroke to mandate coverage for a wide array of alternative care providers.

Chapter Three: Effects of managed behavioral care on clients

Chapter Three will profile individuals being deprived of services because of victimization by the system. Examples of such victimization include eating disordered girls and women , and HIV/AIDS clients being deprived of protease inhibitors who have been victims of the system. Also discussed will be restraints felt by professionals working under the HMO system. In voicing their concerns advocacy groups make presentations and an exploration is made as to why it shouldn't be this way . We suggest that there should be alternatives, which will be outlined in Chapter Four. It will also focus on addressing the question of what "best interests" the HMOs will consider in granting patients care, and how they are prioritized.

Frances (1999) dialogues on women's health issues . He reports that managed -care organizations are refusing to cover the treatments that anorexic women need. Women are dying because of the false notions of these "penny -pinching" bureaucrats. When authors such as Peterson(1988) write and act as advocates for mental health parity and patients, they place complaints on managed care as in the case of an 18 year old, Lafeyette, California native whose fight with an eating disorder was overshadowed by worries about insurance and money, when insurance providers have specialized caps on care because eating disorders are considered mental illness and a $30,000 lifetime cap is placed on 30 days of inpatient care . Hilzenrath (1998) dialogues on how AIDS patients face loss of drugs when HMO's quit Medicare, he raises the awareness how the best known federal health insurance program for the elderly, also

serves younger people with medical disabilities, including AIDS patients. For example , as of January 1, 1998 AETNA U.S. Health Care has announced plans to stop serving Washington Area residence with life sustaining protease inhibitors and other expensive AIDS drugs that could be impossible to replace.

Following the logic of managed behavioral care organizations, more services would mean increases in potential for undesirable medical, psychological, and social risks, lower intensity of services might mean better quality. Selecting only "best risk" patients or denying patients access on the basis of an expensive disease condition, as insurers and purchasers have repeatedly done through non parity mental health services are clearly objectionable. Mental health advocates are split over which persons are worse off because of illness. How much time, money and severity of symptoms and failure of previous treatments has had an effect also factor in to the equation according to Boyle and Callahan (1995).

Managed mental health care could adversely affect the provider/patient relationship. Critics of managed mental health care contend that therapists will have incentives to do less. Therapists will be requested to disclose confidential information to managed mental health care to obtain approval for treatments and continuity of care will be disrupted when gatekeepers direct patients to preferred health professionals. Patients will be persuaded to switch to providers credentialed by managed mental health care organizations and will be directed to psychiatrists when their condition will warrant hospitalization, or therapists will have incentives to do less for patients which could result in therapists' liability as in cases of suicides, after being denied a required four days of hospitalization as reported by Boyle and Callahan (1995). Also, offering

providers financial incentives to provide less care such as "end of year" bonuses or pay increases or placing financial gain and self advantage above patient' best interests indicate how HMO's purchase mental health service and could mandate very restrictive practice guidelines from which providers must not deviate, lest they lose their patients or their jobs.

However, according to the U.S. Supreme Court in 1996, the Jaffe vs. Redmond decision , a key victory , allowed privileged communication to occur in a therapeutic setting. The key to successful psychotherapeutic treatment is communication without the fear of public exposure according to Remly, Herlihy and Herlihy (1996). Kong has reported (1998), the fair and equal coverage of mental health care has long been sought around the nation. Some mental health advocates are opposed to trading off existing patient protections to achieve mental health parity. The Massachusetts mental health bills now require insurers to cover mental health illness. According to Dana (1998), problems with managed mental health care for multicultural populations exist. Managed mental health care has developed a system of care giving that does not recognize that acceptable and effective services must acknowledge individual differences and cultural or racial identities. An approach that does otherwise is unacceptable in an era when a psychology of differences is necessary to provide services for nearly one third of the population. Managed care organizations have seemed to reduce the availability and quality of care for mental health service. Under managed care , pressure is applied to use particular hospitals ,radiology centers, specialists ,and psychotherapists who are on the HMO payroll .A professional counselor/therapist is encouraged to limit the number of consultations with any client as to hold down cost.

An HMO can own a therapist's practice and in turn can become the judge of who gets to receive what kind of treatment which place and for how long. The patient, the actual reason for the existence of both the HMO and the therapists is the potential greater loser.

It has been estimated that more than 80% of patient symptoms are brought to a therapist accompanied by sadness, fatigue, insomnia, loss of appetite, the ability to feel any pleasure or pain, and depression that affects approximately 11,000,000 in that category alone. Who can argue that a purely physical condition is not accompanied by psychological responses. Stress, worry, guilt feelings, anger, have been shown to breed a host of physical complaints, sometimes imagined, mostly real. Ulcers, obesity, hypertension, headaches , asthma, insomnia, , are common conditions related to stress.

According to Rosenhan (1973), diagnostic labels hinder treatment. The evidence has mounted that attitudes toward the mentally ill are characterized by fear, aloofness, suspiciousness and dread Physically, a broken leg does not threaten the observer, but a label of being a schizophrenic remains forever. The general public has no time in understanding the rights and the dignities of those who have experienced emotional illness. The further insinuation that there is an exquisite ambivalence toward the relationship between a mentally ill client and a psychiatrist can only mount if practitioners do not convince a population of clients that rapport is implicit to establish proper mental health care delivery. Finkelstein (1997) reports that for-profit medicine could not care less in the " Sick" business.

Unlike those with a physical illness, persons with mental illness are often perceived to be the cause of their own problems and, for that reason, to be less entitled to generous benefits. People with mental illness are typecast as severely and

persistently ill, while in actuality many suffer only infrequent, mild episodes. People who use outpatient mental health services typically use fewer than ten visits per year. The nature of mental illness is often conceived as a dichotomy between mind and body, which tends to minimize the physical suffering and disability associated with mental illness . Even within the mental health field, some wish to distinguish biological from non-biological mental disorders to give priority to the former in hopes of gaining access to higher medical benefits as reported by Boyle and Callahan (1995).

In an article entitled "Privacy? At most HMOs you don't have any" (1998, July), the anonymous authors report that two years ago, the Harvard Community Health Plan, a Massachusetts-based health maintenance organization, computerized medical records for its 300,000 patients. As a result, the private mental health records, including doctor's notes, were stored in easily accessed electronic files that any HMO employee could see. When news of the privacy breach hit the papers, furious patients forced the HMO to back down. Today, only selected staffers can review the medical files. Mental health records are kept separate from other treatment notes. And the HMO allows patients to review computerized "audit trails" tracking who has viewed their personnel health histories, However, Harvard's rapid response is the exception, hardly the rule. As the number of patients who belong to HMO's had jumped from 6 million since 1976, protecting medical privacy has been a low priority, so low that at many HMO's medical privacy is merely an obstacle to overcome.

Bittner and Bialek and Nathiel and Ringwald,and Tupper(1999) have just reported that an ideal mental health insurance benefit would reduce barriers to initial access, allow intensive treatment of those with the greatest likelihood of gaining from

treatment , and restrict expensive treatment of those with lower levels of need or a high likelihood of improvement without specific intervention(p.338). The idea the authors are conveying is that Mental Health is a minority issue. The road to a just and humane health care system for all people in this country has been a long standing bumpy road. History may demonstrate that the current cost-containment revolution , which has rendered health care a commodity controlled by corporations, is the necessary next step in the process of universalizing coverage while rationing utilization. Until we see better evidence that psychotherapy will have a stake in these new systems , we will continue to take our stand on the outside , counting on people to seek out privacy and quality wherever it is offered. Speaking for the independence and unity of counselors and emphasizing the therapeutic value and the high standards of their profession , counselors need the momentum to move from a detached professional interest in dealing with others to an ongoing substantive practice in a community in which they practice their trade. This is by far a more preferable option in working with managed behavioral care organizations. Why should professional counselors not be allowed to make sound , compassionate and therapeutic decisions themselves? The limits seem to be imposed by " confidentiality" and 'competency" issues.

Chapter Four: The exploration of alternatives

This chapter will explore the alternatives to the current managed behavioral care system. Also, a suggestion will be made to perhaps restructure the instruments by means by which diagnosis is formulated by supplementing such standards as the anonymous writer (1999) has reported. Rather examine the structure of the health care system, it may be better to examine the salvageable elements in our current mental health care delivery from the DSM1V to include multi cultural populations .

The solution to overcome these biases may be found in providing all parties who have a stake in the matter a say, (e.g. patients, health care professionals), and the managed mental health care organizations. An anonymous author (1999) has reported that the issue of employer- provided coverage is a complicated one , and will be likely subjected to increasing debate. The current American Health Care system is based on insurance provided on a voluntary , albeit tax-subsidized , basis by millions of employers across the nation. According to the author, it is fascinating to observe how the health care debate has been turned on its heels since 1994, when President Clinton was fighting for his Universal Health Care plan. At that time the size of the uninsured population was the prime motivating factor behind President Clinton's plan. Currently the roles of the uninsured in America is 44 million and is growing by 100,000 per month.

Holmer (1999) has reported that all seniors citizens need coverage . approximately 35% of senior Medicare beneficiaries are lacking insurance coverage for prescription drugs. Prescription drugs today are as important as a hospital bed was in 1965. In order to prevent frequent visits to the emergency room and hospital and nursing

homes, modernizing the access to prescription drugs by empowering seniors to choose between competitive private-sector health plans with government paying the major part of the premium is a choice worth considering . According to Holmer (1999) the pharmaceutical companies think decisions about what medicines should be available to seniors should be made by physicians and not by government clerks. Medicines that treat osteoporosis can help women remain active while saving health care dollars. A single hip fracture costs an estimated $41,000.00 per patient . Fifteen years of treatment with a leading pharmaceutical to prevent the same condition costs only $3,000.00. Since US Pharmaceuticals are investing billions of dollars in the search for the cure for the diseases of aging. Massachusetts biotechnology leads this effort. Modernizing Medicare to allow seniors the benefit of medicines that save lives without reforms ridden with regulation and price control would enhance their lives. By the same token allowing seniors the choice of outpatient visitation to a licensed professional counselor is an obvious next step in the same process.

Goodman (1999) ,has reported that now that the furor over patients' rights is settling down, we could all try a bit of alternative medicine. When both Democrats and Republicans passed out bitter pills of their vision of health care on the floors, patients felt stuck with mismanaged care, and doctors felt like they were hired help. Who could be surprised by reports that patients in non-profit HMO's were getting better care than patients in for-profit HMO's. We have come through a decade of wild change. Today, the insurance companies seem to be in charge of health care decisions. Managed care has kept costs down while raising suspicions in the minds of patients everywhere. Insurers have a financial incentive to do nothing. People are wanting to

fight insurance bureaucrats. HMO's are even lower in the public trust than journalists. The issue of wresting some control back from the managers is on the political agenda. Harvard's Robert Bland (1999) frames it this way, " How can you selectively overturn the insurance company's decisions which limit the ability to get the treatment you and your physician / therapist think is appropriate? Goodman (1999) goes further to report that both political parties are practicing medical minimalism. They offer protection to the already insured while there are 44 million people out there with no insurance at all.

Patla (1999) has indicated that Kid Care, the Children's Health Insurance Programs (CHIPs) and similar programs in Chicago to insure children and pregnant women has enrolled some 10,000 children since inception on April 12,1999. Kong (1999), has dialogued that the U.S. Government made $24 billion available two years ago to help provide health care coverage for at least 5 million un -insured children by the year 2002, just a little more than a million have been signed up.CHIPs were first created in 1997 to provide $24 billion in federal matching funds to states over five years . The reason for such an outlay was to address one of the symptoms of the nation's ailing health system: children who go without needed medical care because they have no insurance. This program represents one of the most comprehensive attempts to change the way the nation covers children since the Medicaid program began thirty years ago. The goal is to insure five million children and pregnant women by the year 2002. The program still carries the worry that 6 million children may be without coverage. Then latest analysis shows that 11 million , or 15% of all children in the United States ,are insured at any one time. In Massachusetts, just over 46,000 were enrolled in CHIP-

funded programs as of the end of June,1999. M ore than 100,000 children still remain without coverage. Also, there are 19,000 children enrolled in Children's Medical Security Plan.

Regarding the generation at the other end of the age spectrum, Holmer (1999) has reporter that millions of senior citizens lack insurance coverage for prescription drugs. An anonymous writer (1999) has reported that rather than examine the structure of the health care system, it may be better to examine the salvageable elements in our current mental health care delivery. Modernizing Medicare to include expanding prescription drugs coverage is an optional alternative being seriously considered. If consumers want universal health care coverage, why would they support only employer provided coverage? If consumers want low cost coverage, why would they support expensive mandates on health plans? If consumers want efficient utilization of health care through managed care , why would consumers support Congressional approvals for restrictive attitudes toward mental health care delivery?

Among the list of alternatives, Bittner and Bilaek;and Nathiel and Ringwald and Tupper (1999) have reported that the Connecticut Psychotherapist's Guild is one of a growing number of associations of psychotherapists from various disciplines that have decided not to participate in the managed care revolution currently restructuring health care in the United States The members of our Guild in Connecticut have joined together to share information, to support each other, and to offer an alternative to managed behavioral care. They are not clinically affiliated , not mutually liable, not hierarchically structured by profession; neither are they affiliated by school of

thought, training, experience , area of expertise , or political leanings. They are not "out to get contracts"

The Guild is attempting to preserve a space in the culture for therapy whose quality is measured by patients ,peers, and research rather than by entrepreneurs, computers, and committees. We have come to this position out of a conviction that practicing psychotherapy in the corporate health care system makes it too difficult for us to adhere to strict confidentiality and other ethical values. Bittner and Bialek and Nathaniel and Ringwald and Tupper (1999), feel that mental health professionals will have to work to remain stakeholders at the decision making table. To advocate for the possibility that psychotherapy can remain an option for some, the Guild is convinced that they offer therapies that preserve choice and privacy. As a result the Guild feels that families and individuals will seek them out as they did in the years before psychotherapy became part of insurance coverage.

An alternative similar to the above established Connecticut " Guild", is the establishment of "Boutique Medicines" . According to Sharpe (1998), doctors are treating patients as precious , for the right price. Consultancy groups are forming and favoring the wealthy who wish to avoid the HMO. Attentive care is being considered by physicians and therapists and there is nò reason to rule out psychiatrists and therapist practitioners will join .

Rauber (1998) has reported that in modern mental health care , alternative providers are being used ,even if for the time being . In Washington state a federal appeals court has upheld to offer enrollees access to licensed alternative care providers . Potomac (1999) reports that hospitals are posturing to seize consumer demand for

alternative care. Alternative therapies are becoming increasingly mainstream. The National Institute of Health and the Office of Alternative Medicine has reported that alternative therapies are being used in at least 34 of the nation's 125 medical schools. Leah Kliger , principal with The Lake Group , an alternative care consulting firm in Lake Stevens , Washington ,provides marketing strategies for creating alternative programs at The Alliance for HealthCare Strategy and Marketing held in March, 1999 in San Francisco.

It is hoped that The Massachusetts Mental Health Counselor's Association can consult with similar marketing firms in Massachusetts to enhance the professional counselors they represent. As of this research writing Massachusetts allows third party reimbursement to licensed mental health counselors through it's Blue Cross Blue/ Shield organization . This writer concurs with Potomac (1999) that there should be a "champion" to banner the cause of the profession of counseling and muster the influence of administrative support to find alternatives to providing psychotherapy under only managed behavioral care organizations and Health Maintenance Organizations.

SUMMARY AND CONCLUSIONS

In this research the writer utilized the comparison of the historic past and the contemporary scene. He compared the treatment of mental illness over the span of fee-for service systems or uninsured systems to the contemporary scene of uninsured mental health populations as well as those covered by behavioral health maintenance organizations.

There are trends that remain imbedded in the current systems and there are glimpses of hope for a system that seems to be in a state of transition. It has been said that the only way to replace an archaic way of thinking is to let it's leaders die off. It is the premise of this research that at the dawn of the twenty first century, a post modern view has developed among a large number of individuals that view any form of therapy as cynical and demeaning. This view is also held by many about the nature of human beings. The leaders who have formed their scientific explanations for any formative cure for mental disorders are leaning toward a constructivist/developmental model that is also in a state of transition. Examples of alternative means to assess and reconceptualize mental illness are being developed by such innovators as Ivey (1999) These innovations have implications for style and intervention strategies for professional counselors.

Anderson(1990) has reported that a major shift is occurring in Western perception of the sources of knowledge and authority . The post modern era is pervaded in skepticism about the attempt to define reality and truth. There are forces in the counseling profession that are focusing on including context and multiple realities in their approach to the dilemma of mental illness. Collaboration and mutual

assent toward any dynamic, social, behavioral or biological change are seen to be preferable options over controversial methods of treatment such as involuntary restraint, involuntary commitment, involuntary seclusion, or involuntary hospitalization.

On July 10, 1998, Jeff McLaughlin of The Boston Globe wrote an article, "Beacon Hill winds down frenzy" in which he mentioned that for the past number of years, a managed care reform bill which would regulate HMO's may emerge as a bill that Theresa Murray and Representative Kathleen M. Teehan (Democrats of Whitman), among others , have championed the same bill along with Representative Paul R. Haley (Democrat of Weymouth). The Massachusetts legislators feel that managed care "regulation" for the past thirty years has been unregulated. Lastly, in The Boston Globe, Alex Pham wrote on July 14, 1998 that Mary Lou Buyse has been nominated to head the Massachusetts Medical Society. Speaking for 17,000 physicians, Mary Lou is a former HMO executive. Taunton's J. Timothy Hogan, a Taunton Publisher who blamed the "Health System" for the inability to locate treatments for his depression published an article in Hogan's Taunton Gazette in which he chronicled denials of coverage for his depression from the United Health Care system. The same company that Mary Lou Buyse consults for and which she was a medical director until November 1998. So far, Buyse has managed care's approval for avoiding lightening rod issues. Physician dissatisfaction with HMO's revolves on a number of issues. On for profit care, Buyse has said " I go by who works in the companies rather than their tax status". Regarding the high profile role of pushing for managed care reform has been delegated to three medical society members, Dr. Alan Carroll, Dr. Jack Evjy, Dr. Alan Wood while Dr. Mary Lou Buyse will take a back seat to this issue.

"Even as your plastic HMO membership card is sitting snugly in your wallet, your mental health benefit coverage for therapy, in-patient psychiatric care, and sometimes drug treatments are most likely being farmed out to an entirely different business whose name is nowhere on your card" as Lerner (1999) reports .

As of January, 1999 while we were sleeping, psychologists who were making $72.00 per hour for a 50 minute session in the Empire State network are now getting $50.00 per session. Since Magellan oversees the benefits of over 62 million lives, even if you switch HMO's you probably will still end up with Magellan making your mental health decisions. The companies will tell you that takeover is good for patients by saying, "We put mental health under the supervision of experts".

Is disease management in the mental health community making any substantive adjustments for a growing population of "AT RISK" groups and individuals? The addition of how the chain of command works in a managed care organization is outlined with reference given to the "Distant Parent Company" that generally operates in a "Closed" system environment. This paper has maintained that the strategies and the tactics used to limit the treatments and care for mental illnesses such as substance abuse can also include restricting access to marriage and family counseling and therapy.

Chief Executive Officer Henry T. Arkin states that The Magellan Health Services is now the biggest company in managed behavioral care with 62 million Americans covered. The monolithic proportions of MCO's and HMO's are addressed by New England Legislators.

In referencing the archives of Counseling Today titled Professional Counselors and managed care, English and Marino (1998) write that when it comes to managed care, counselors aren't necessarily following the rule. According to a survey of more than 1200 counselors conducted by Howard Smith, chair of the ACA Professionalization Committee, the majority of counselors are working outside of managed care. Sixty five percent of counselors surveyed receive one quarter or less of their income from managed care. The resistance stems from a long list of complaints with managed care by professional counselors, including lower fees, delays in payments by managed care, and concerns about managed care's impact on client's confidentiality. Fees paid by managed care plans for individual and group therapy have decreased 10-15 percent or more over the last four years.

Even Joyce Breasure, a professional counselor in Wyoming, Del. and past President of ACA, believes that managed care unethically handles mental health. For instance, it is not possible to predict how long it will take a leg to heal, yet managed care plans often rule that certain "Mental Health" problems must be healed within a few visits. To cite the most reliable of sources, Hubler (1999) reports that HMO's do lag in mental health policies, and a Denver Post survey has concluded that that a "D" average on the report card has been given to HMO's. Psychiatrists and other mental health workers in Colorado have released. It was the first time that all of the organizations of mental health providers that are licensed and regulated in the state of Colorado came together to share their experience with the public about how much cooperation really exists between managed care and providers. Hubler (1999) ,has concluded that the professionals have stopped short of accusing the managed care

industry of denying necessary treatments. The hurdles the patients and the providers have had to negotiate to gain approval of care have created a lot of frustration. That is the last thing someone needs in seeking mental health services and needs. The report card that was issued in Colorado was intended to shake up the managed care industry, and early indications are that it is working. Three companions have contracted the Colorado Psychiatric Society. The state of Colorado's biggest plans with almost 400,000 members , Pacific Care Behavioral Health, will hold "Town Meetings" with mental health providers statewide to get conversation rolling. For example, Hubler, (1999) reports that " for a psychiatrist , a typical kind of authorization would be for one assessment visit , then you might have a couple of follow -up medication visits. , " But there is an absolute assumption in that allocation that the psychiatrist isn't really going to be talking much with patients about the problems in their lives other than , " Are you taking your medication and are you having any side affects from it". Hubler,(1999) further writes that " it used to be that providing therapy just involved the therapist and the patient". "It is true that somebody now is looking over the treatment that is being delivered and making an assessment of the quality of that care. It is a very different model, and one that I think a lot of providers do not feel comfortable with.

One bill that would have a greater impact on professional counselors and clients is the Patient Access to Responsible Care Act (PARCA). PARCA (H.R. 1415 and S.644) was introduced by Republicans (Norwood - GA and D'Amato –NY). Among a host of consumer protection provisions, the bill would require managed care

plans to have a mix of health care professionals on staff, and would prohibit health plans from discriminating against professionals on the basis of their type of license.

By researching and writing about these issues, this student IRP intended this IRP to promote a profession worthy of its calling in addressing the needs of an ever-growing populus that may someday require the services of a consultant to whom they can turn in their communities and vent their concerns. As of this writing there are 44 million Americans who have no insurance whatsoever. There is a return to "hyperindividualism " a feature so widely admired by western philosophies, yet so difficulty for peoples of ethnically diverse persuasions to accept.

It is hoped that .

1. Newly licensed mental health practitioners will gain an awareness of the issues which will face them as they run up against HMOs and how to protect their own interests while maintaining integrity in their treatment of mental health patients. In so doing professional counselors should use their increased awareness to help them work effectively with their clients.

2. To promote an awareness of any ethical concerns that may result as managed care organizations dictate the type of treatment towards a population considered mentally ill.

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APPENDICES

APPENDIX A: The effects of managed behavioral care on clients and consumers. Questionnaires and Results in Graph and Numerical Form

The respondents who were given the questionnaire designed for clients and consumers gave the following responses according to the questions here stated.

Question One: Do you see yourself treated any differently from a physical disease?

Question Two: Do you feel any service has been denied?

Question Three: Would you say that you subscribe to an HMO for your mental health treatment needs?

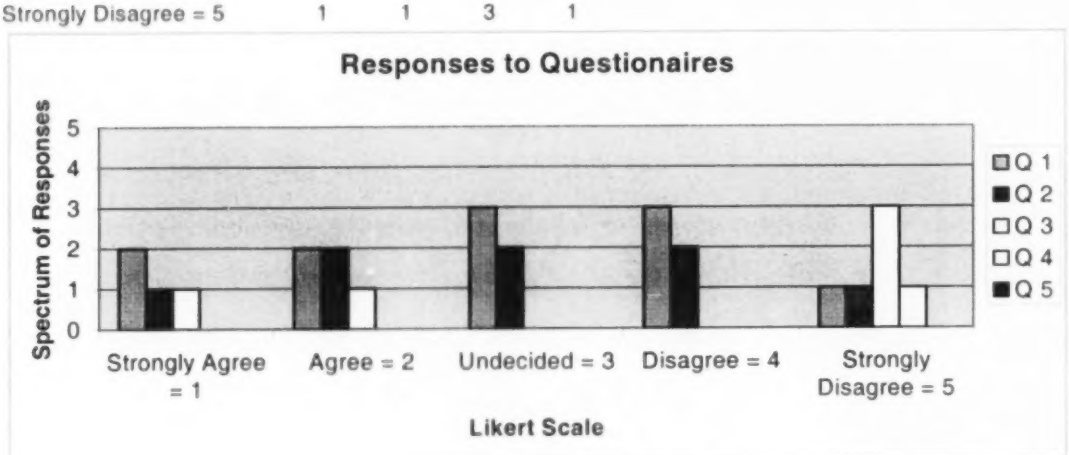
Question Four: Do you feel there are limits to your treatment options?

Question Five: Do you feel a "Patient Heal Thyself" has evolved?

Question Six: Do you feel out of the " Mainstream " of society?

Out of a sample of 5 questionnaire prompts: The respondents yielded a total of five consumer/client results.

Strongly Disagree = 5 1 1 3 1



APPENDIX B: Questionnaires and Chart for Therapists And Clinicians

Question One: Do the clients or consumers to whom you provide a service feel neglected by HMO's and MCO's?

Question Two: Do you feel as if you are providing "Stepchild" treatment?

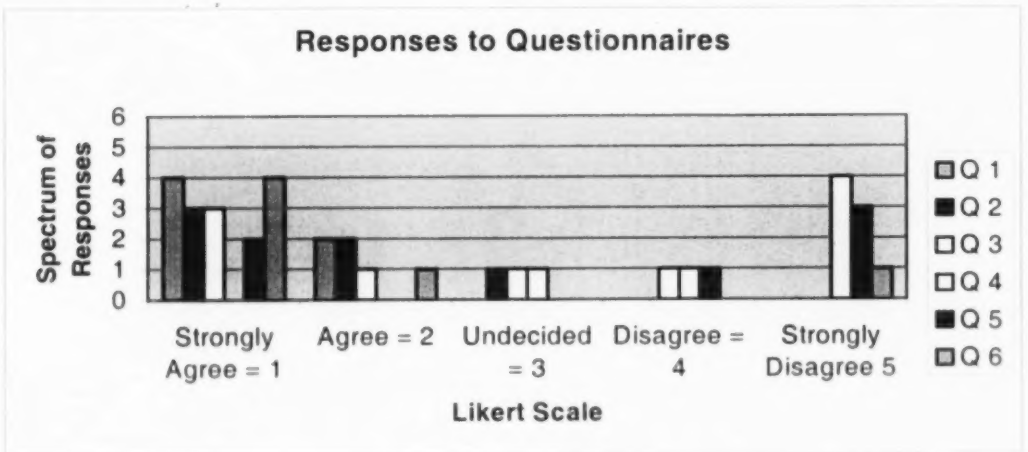
Question Three: Do you feel as if you are receiving " Step child" treatment?

Question Four: Are you aware of the Jaffe vs.Redmond decision?

Question Five: Are you legally protected by " Privileged " communication statutes ?

Question Six: Do you feel that you should be in complete collaboration with managed behavioral care organizations?

	Q 1	Q 2	Q 3	Q 4	Q 5	Q 6
Strongly Agree = 1		4	3	3		2	4
Agree = 2		2	2	1			1
Undecided = 3			1	1	1		
Disagree = 4				1	1	1	
Strongly Disagree 5					4	3	1



Appendix C: Questionnaire and Chart responses for Executives
Table outlining managed behavioral care and CEO protection from liability

The two executives who were interviewed gave the following responses according to the questions here stated.

Question One: Is there anything unique about the service of your HMO? Both felt that they were unique.

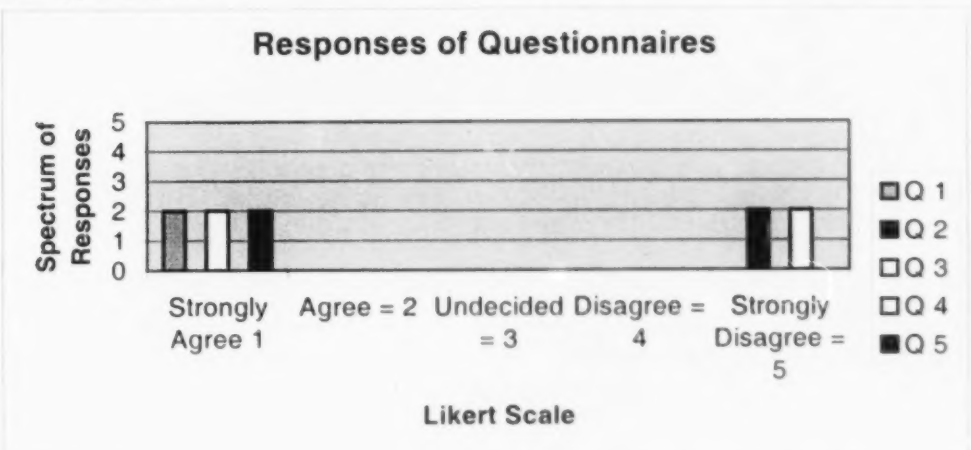
Question Two: Do you feel responsible if the therapist in your HMO is liable for providing negligent care? Both disagreed.

Question Three: Do you feel yourself to be in the health care "business"? Both agreed.

Question Four: Will the therapist to whom you provide reimbursement have a controlling interest in deciding what type of care or therapy is provided? Both disagreed.

Question 5: Is a "closed" management style preferable to an "open" style? Both agreed.

	Q 1	Q 2	Q 3	Q 4	Q 5
Strongly Agree 1		2		2	2
Agree = 2					
Undecided = 3					
Disagree = 4					
Strongly Disagree = 5			2		2



Curriculum Vitae

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Experience :

1997 to Present Boston Public Schools Boston, MA
Replacement Teacher/ Substitute Teacher
Ensured safety, implemented lesson plans, adapted lessons to enhance learning, tutored general as well as special needs.

1998 to Present Boston Public Schools/Summer Program Boston, MA
Teaching Assistant
Ensured the safety of economically/ developmentally challenged boys and girls. along with speech pathologists, registered nurses, occupational therapists.

1987 to 1991 *Estate Coordinator* St. Petersburg, FL
Coordinated the estate of a deceased relative (Mother). Worked with Attorneys, Bankers, Real Estate Brokers , and Local Officials.

1964 to 1967 The United States Army Berlin, Germany
Three Terms of Honorable Service
Recipient of (Cold War Recognition) certificate
Medical Corpsman

Education:

1998 to Present Cambridge College Cambridge, MA
Currently graduate student candidate, Ed. M. degree.
Completing national and state licensure requirements, Counseling Psychology

1980 to 1982 University of Northern Colorado Greeley, CO
Master of Arts in Counseling Psychology
A CACREP Approved Program

1979 to 1980 Control Data Institute Cambridge, MA
Certificate: Computer Programming /Operations

1974 to 1976 University of Massachusetts/ Boston Dorchester, MA
Bachelor of Arts in Psychology

1971 to 1973 Lesley College Cambridge, MA
Associate of Arts (*Magna cum Laude*)

Affiliations:

Professional Member: American Counseling Association/ACES
Professional Member: Massachusetts Mental Health Counselor's Association (MaMHCA)
Member: Marquis Who's Who in the East 1999-2000
Member: Marquis Who's Who in America America'54 (The Millenium Edition)
Member: The International Biographical Society
Member: Amnesty International
Member: American Civil Liberties Union
NBCC Eligible: Board Certified Professional Counselor